Link to Final Agency Decision
OAH 8-0900-19006-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HEALTH

In the Matter of Martin Luther Manor **RECOMMENDED DECISION**

The above matter was the subject of an informal dispute resolution meeting conducted by Administrative Law Judge Eric L. Lipman on August 6, 2007. The meeting concluded on that date.

Marci Martinson, Unit Supervisor, Division of Compliance Monitoring, 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970 represented the Minnesota Department of Health ("the Department"). Mary Cahill also attended the meeting and made comments on behalf of the Department.

Natalie Morland, R.N., Carolee Alexander, R.N., and Jody Barney appeared on behalf of Martin Luther Manor, 1401 East 100th Street, Bloomington , MN 55425 ("MLM" or "the facility").

As detailed in the Memorandum that follows, based upon the documentary exhibits, arguments and applicable case law, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

The Commissioner should further recommend that Tag F-309 be SUSTAINED.

Dated this 20th day of August, 2007.

s/Eric L. Lipman
ERIC L. LIPMAN
Administrative Law Judge

Reported: Digitally Recorded
No transcript prepared

NOTICE

Under Minn. Stat. § 144A.10, subdivision 16 (d) (6), this recommended decision is not binding upon the Commissioner of Health. Further, pursuant to Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility, indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge, within 10 calendar days of receipt of this recommended decision.

MEMORANDUM

This matter arises out of a survey at Martin Luther Manor ("MLM") in May of 2007. On May 23, 2007, the Minnesota Department of Health ("MDH") issued a Statement of Deficiencies designating a series of "F-Tags." These tags set forth areas in which the Department asserts that MLM fell below the federal requirements for participation in the Medicare and Medicaid programs. If sustained, such a deficiency could result in the application of sanctions to MLM.

General Statutory and Regulatory Background

Participation requirements for skilled nursing and other long-term care facilities in the Medicare program are set forth in 42 C.F.R. Part 483, Subpart B. Provisions governing the surveying of long-term care facilities and enforcement of their compliance with participation requirements are in 42 C.F.R. Part 488, Subparts E and F.

Federal Medicare and Medicaid authorities assure compliance with the participation requirements through regular surveys by state agencies. The survey agency reports any "deficiencies" on a standard form called a "Statement of Deficiencies."[1]

A "deficiency" is a failure to a meet a participation requirement in 42 C.F.R. Part 483.[2] Deficiency findings are organized in the Statement of Deficiencies under alpha-numeric "tags," with each tag corresponding to a regulatory requirement in Part 483.[3] The facts alleged under each tag may include a number of survey findings, which (if upheld) would support the conclusion that a facility failed to meet the regulatory standards.

A survey agency's findings also include a determination as to the "seriousness" of each deficiency.[4] The seriousness of a deficiency depends upon both its "scope" and its "severity."[5]

When citing deficiencies, state surveyors use the Centers for Medicare and Medicaid Services (CMS) "Chart of Enforcement Remedies" (otherwise known as the "Scope and Severity Grid" or "the Grid"). The level of deficiency

and the enforcement action to be taken is set out on each square of the Grid. Each square on the Grid has a letter designation. A is the least serious, and L is the most serious.[6]

A facility becomes subject to remedial action under the participation agreement when it is not in "substantial compliance" with one or more regulatory standards.[7] A facility is not in substantial compliance with a participation requirement if there is a deficiency that creates at least the "potential for more than minimal harm" to one or more residents.[8]

If a facility is found not to be in "substantial compliance," CMS may either terminate the facility's provider agreement or allow the facility the opportunity to correct the deficiencies pursuant to a plan of correction.[9] Further, CMS may, based upon the severity of the deficiencies, impose an intermediate remedy, such as a monetary penalty, for each day in which the facility was not in substantial compliance with the terms of the participation agreement.[10]

Lastly, Minnesota Statutes §144A.10, Subdivision 16, establishes a process for independent and informal resolution of disputes between survey agencies and health care providers with a participation agreement. In this request for Independent Informal Dispute Resolution, MLM submits one F-Tag for review.

Tag F-309 – Care for the Resident's Highest Practicable Well-Being

A. Regulatory Standards and Surveyor Claims

Federal law requires that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."[11] "Highest practicable" is defined as the highest level of functioning possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline.[12] So as to guide the delivery of services the facility is likewise obliged to conduct initial and periodic assessments of the resident that are "comprehensive, accurate, standardized, and reproducible."[13]

Where there is a lack of improvement or a decline, surveyors must determine if the occurrence was avoidable or unavoidable. A determination that a decline was unavoidable can only be reached if the facility has an accurate and complete assessment of the resident, a care plan which is implemented consistently and based on information from the assessment, and an evaluation of the results of any interventions and revision of the interventions as necessary.[14]

B. Resident 12

At the time of the state survey, Resident 12 was an 81 year-old woman with a pyramiding serious of serious health conditions. She had a history of myocardial infarctions, congestive heart failure, interstitial edema, peripheral vascular disease and venous insufficiency.[15] Furthermore, Resident 12 suffered from cognitive impairments which impeded her ability to communicate with caregivers.[16]

So as to improve this Resident's stability while walking, her mobility and her overall activity level, in mid-April of 2007 she was fitted with an ankle-foot orthotic device (AFO).[17]

The F Tag at issue in this matter centers on whether MLM staff sufficiently noted and treated a leg wound that began as a skin tear in Resident 12's anterior left ankle, but over time worsened into a more serious wound. The Department has three principal contentions. It asserts that not only was the documentation regarding the size and severity of the wound inaccurate,[18] but that without the correct assessment data MLM could not establish that the appropriate interventions were being made.[19] Moreover, without either accurate data or assessments, the Department asserts that MLM cannot exclude the use of the AFO as the cause of irritation to, and worsening of, the ankle wound.[20]

By way of reply, MLM makes two key contentions. First, MLM vigorously asserts that the interventions required to treat Resident 12's other heart-related health conditions impeded better progress on the healing of the skin tear on her left ankle. For example, MLM points to its provision of supplemental oxygen and diuretics in response to the more serious conditions,[21] as well as Resident 12's own venous insufficiency,[22] as essential to understanding why this patient's leg did not heal more quickly. In MLM's view, therefore, in the context of Resident 12's other serious conditions (which led to her death a few days after the survey was concluded[23]), the responses that her wound made to the interventions were "within the limits of recognized pathology and the normal aging process."[24]

Second, and likewise important, MLM hinted during the dispute resolution conference that to the extent that MLM staff agreed that the wound had grown larger by the time of the survey, the documentation of the increasing wound size,[25] and the conclusion that the orthotic device could have been a cause of the wound,[26] were prompted by an aggressive surveyor.[27]

Unquestionably, MLM is correct that its staff was employing multiple interventions to treat a Resident with difficult health conditions, undertaking regular reviews this patient and updating its interventions and care plans based upon these reviews. Viewed from this lens, MLM was certainly vigilant and capable in its delivery of health care services.

The challenge, of course, is that while the best explanation of the source of Resident 12's wound and the true meaning of the Nurse Manager's statements regarding the AFO as a potential cause of later bruising, might be clear to MLM staff, their views do not find solid support in the health care records as they were developed. MLM's claim that the AFO was considered and rejected as a cause of the bruising (in favor of symptoms which were co-occurring with the Resident 12's heart condition), would be sturdier if this conclusion had been reduced to writing in the integrated notes or other accompanying records. Likewise, the apparent acceptance of the surveyor's wound measurements on May 10, 2007,[28] and the acknowledgement that the AFO fitting was a potential cause of bruising that needed to be excluded,[29] hobble MLM's more recent arguments that these parts of the record were made under official pressure and are not to be believed.

Accordingly, while MLM might have been able to establish its compliance with the regulations upon another, more detailed record, that record is not before OAH today. The Commissioner should recommend that this Tag be sustained.

E.L.L.

[1] *See*, 42 C.F.R. § 488.325 (a) (2005); CMS State Operations Manual, Appendix P, Section IV.

[2] *See*, 42 C.F.R. § 488.301 (2005).

[3] CMS State Operations Manual, Appendix P, Section IV.

[4] *See*, 42 C.F.R. § 488.404 (2005).

[5] *See,* Ex. C.

[6] *See,* Ex. C-4.

[7] *See,* 42 C.F.R. § 488.400 (2005).

[8] *See,* 42 C.F.R. § 488.301 (2005).

[9] *See,* 42 C.F.R. §§ 488.402, 488.406 and 488.412. (2005).

[10] *See,* 42 C.F.R. §§ 488.406, 488.408 and 488.440 (2005).

[11] *See,* 42 C.F.R. § 483.25 (2005).

[12] *See,* Ex. E-1.

[13] *See,* 42 C.F.R. §§ 483.20, 483.25 (2005).

[14] *See,* Ex. E-3, State Operations Manual, App. P, Tag F 309.

[15] *See,* Ex. 1 at 1-4; Ex. 4 at 1-2.

[16] *See,* Ex. 5, Minimum Data Set Form of March 8, 2007.

[17] *See,* Ex. 7 at 7-8.

[18] *See,* MDH Survey Exit Summary at 10-11.

[19] *Id.*

[20] *Id.*

[21] *See,* Ex. at 1-4.

[22] *See,* Ex. 1 at 4.

[23] *See,* Ex. H-42b.

[24] *See,* Ex. E-1, State Operations Manual, App. P, Tag F 309.

[25] *See generally,* Ex. D-5 and D-6.

[26] *Id.* at D-6.

[27] *Compare,* Ex. J with Dispute Resolution Conference Recording at 1:35 (August 6, 2007).

[28] *See,* H-42b and Ex 6, Impaired Skin Flow Sheet of May 9, 2007.

[29] *See,* Exs. H-42b and J; Dispute Resolution Conference Recording at 1:35.